**Self-Referral to headspace Lithgow**

**For yourself, family or friend…….**

**STOP** Professional referrer Please use ‘professional referral form Thanks….

|  |
| --- |
| **There are a few ways you can contact headspace Lithgow for an appointment. You are welcome to use the method that is most comfortable and convenient for you***Call us on the* ***Phone*** *at 6352 7600* *Return this form via* ***email****:* hs.Lithgow@marathonhealth.com.au*Come into the* ***centre:*** *23 Main St, Lithgow, 2790*  |
| **Young person Details:**  |
| First Name: | Last Name:  |
| Date of Birth: | Sex:  |
| Address:  |
| Suburb:  | Postcode: |
| Phone Contact:  |
| What do you hope **headspace** Lithgow can help you with?  |
|  |
|  |
|  |
|  |
|  |
| In addition, would you like to speak with someone who can help you with … * Drug and Alcohol issues Yes / No / Maybe
* Vocational and Employment Issues Yes / No / Maybe
 |
| **Can we sign you up to Spaces?** Yes / No headspace Spaces contain things you might find useful. Including, articles, videos, fact sheets, and free online and telephone support and counselling to young people 12 - 25 and their families and friends. It provides a safe, secure and anonymous place to talk. **Password will be set as hsLithgow1** |
| Have you **previously** seen another health practitioner? (e.g. Psychologist, Social Worker, Counsellor, Doctor)Yes / No  | Are you **currently** engaged with, or have previously seen another health practitioner? (e.g. Psychologist, Social Worker, Counsellor, Doctor) Yes / No  |
| If yes, Practitioner Name: |
| **Supports:** If under 16 are your parents / carers aware of this referral? YES / NO (please circle)Do you currently access any other support organisations? YES / NO (please circle) Do you have a current Mental Health Care Plan? YES / NO (please circle) Is there a Family Member / worker you would like us to speak to? YES / NO (please circle)Their Name:Contact number:Relationship to you:  |
| REFERRER INFORMATION: (if a family member / carer / friend has completed this form)**Name:****Relationship to young person:****Contact number:****Does the YP know about this referral?** Yes [ ] *If not, the referral cannot be accepted. Get in touch and we’ll talk you through some other options.* **Is the YP between 12 and 25 years of age?** Yes [ ]  |
|  **Do you believe this young person is at risk of harm to themselves or other people?** [ ]  Yes [ ]  Noheadspace is an early intervention and prevention service. If the young person is at risk of harm to themselves or to someone else, they are no suitable for headspace services. Please contact the mental health hotline on 1800 011 511 (24 hours) for appropriate services, take them to your nearest hospital, or call 000. |